STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265294	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Carrollton	300 Life Care Lane Carrollton, MO 64633

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect one residents right to be free from abuse when Resident #2 hit Resident #1 in the face with an open hand. This affected one of four sampled residents. The facility census was 58.Review of the facility abuse policies updated 04/01/2026 include: - It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation; -The resident has a right to be free from abuse - Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse; - Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Review of Resident #1's care plan dated 12/28/25, showed: -The resident had the potential to be physically aggressive and had a history of hitting staff, related to a diagnosis of vascular dementia;-The resident was at risk of being unable to make his/her needs be known due to diagnosis of dementia.Review of Resident #2's care plan, dated 01/09/26, showed: -The resident used a walker to walk and a wheelchair for long distance walking;-The resident had impaired communication due to dementia;-The resident was at risk of changes in mood due to dementia;-The resident's care plan addressed that the resident displays inappropriate behavior towards staff members but not towards other residents. Review of the Resident#1s progress note, dated 03/25/25, showed Licensed Practical Nurse (LPN) A documented Resident #1 and Resident #2 were yelling at each other and by the time he/she got to the residents, Resident #2 hit Resident #1 on the left side of his/her face with his/her open hand. He/she was able to separate the residents and Resident #2 was placed on one-on-one observation to monitor his/her behavior and ensure no other residents were hit. Review of the facilities abuse investigation, dated 03/25/26, showed: -Resident #1 refused to give Resident #2 his/her walker, Resident #2 then struck Resident #2;-Both residents were separated immediately;-Resident #2 was placed on one-on-one supervision by staff; -Neither resident had any injuries;-Contributing factors towards the incident: cognitive impairment, similar equipment (walkers not easily distinguishable), possible unmet psychosocial needs (anxiety, territorial behavior). Review of Resident #2's nursing progress note, dated 03/25/26, showed: -LPN A documented that Resident #2 hit a resident on the left side of the face with his/her open hand;-Both residents were separated and Resident #2 was placed on one-on-one monitoring by staff to ensure this did not occur again. During an interview on 04/02/2026 at 12:10 P.M. Licensed Practical Nurse (LPN) A said:- NA A and LPN A were the only staff on the hall at the time of the incident;-He/She was at the other end of the hallway passing medications when the nursing assistant (NA) A yelled for help for assistance with Resident #1 and Resident #2;-When he/she got to the residents NA A was beside the residents and LPN A witnessed Resident #2 hit Resident #1 across the left side of his/her face with an open hand;-LPN A separated the residents and placed Resident #2 on one-on-one observation with certified nursing assistant (CNA) A;-Resident #2 had been verbally agitated with Resident #1 in the past and has said that he/she did not like him/her.-The residents had not had any physical altercations prior to this one;-A resident hitting another resident is considered abuse. During an interview on 04/02/2026 at 12:16 P.M. CNA A said:-He/She provided one-on-one supervision of Resident #2 after Resident #2 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hit Resident #1 with his/her open hand;-A resident hitting another resident is abuse. During an interview on 04/02/2026 at 2:30 P.M. the Administrator said:- Nursing staff had been in-serviced on abuse and neglect on 3/16/26, prior to the incident;- After Resident #2 hit Resident #1, staff received de-escalation training;- Since staff had recently been provided with abuse and neglect training, training was not provided again. - Residents have the right to be free from abuse. Intake 2964661